

Health Policy Brief

July 23, 2009

Coverage for Low-Income People: Should the Medicaid program be expanded to cover more of the uninsured? Should there be changes in the Children's Health Insurance Program?

What's the issue?

Among measures to help nearly 50 million uninsured Americans get health insurance, Congress is considering major changes in two programs for low-income people: Medicaid and CHIP, the Children's Health Insurance Program. Some proposals would increase enrollment in Medicaid by raising the levels of income that people could have and still be eligible for the programs, and by including another group that now doesn't qualify: adults who don't have dependent children. Other measures would allow low-income individuals and families to buy private health insurance with the assistance of federal subsidies, or to enroll in a newly created public health insurance plan.

These ideas have reignited debate in key areas: about the merits of Medicaid and CHIP, compared to private insurance; and about how to improve these two programs while trying to control costs. Many members of Congress, and stakeholder groups that have engaged in health reform discussions, agree that some expansion of the programs is probably necessary, given the lack of affordable private health insurance policies for poor and low-income people. But how far should the expansion

go? What would be the effect on state and federal budgets? What should be the mix of public program expansions and private coverage? Given the pressures on the federal budget and the difficulty in finding new sources of revenue, can the government really afford to expand public health insurance programs or provide subsidies for low-income families to purchase private coverage? If not, how else will uninsured low-income people gain health insurance?

Dispute: In Congress, the response to these issues breaks down to some extent along partisan and ideological lines. Many Democrats support a broad expansion of Medicaid, as well as creating opportunities for CHIP enrollees to participate in a proposed new Health Insurance Exchange and enroll in either a private or public plan option. Many Republicans are resisting proposed expansions of Medicaid, as well as the separate public plan option, and calling these another step along the road to government assuming the responsibility for financing all of health care. Among concerned stakeholders outside the federal government are governors. Although many support efforts to expand coverage, they are worried about the implications for state finances.

What's the background?

Medicaid is a federal-state government partnership established in 1965 that serves almost 61 million low-income and disabled beneficiaries (in 2007, the latest available data). Nearly half of enrollees are children under age 19; 15 million enrollees are adults, and 8 million are people with disabilities below age 65. Medicaid is also the nation's only source of significant long-term care financing and covers 3 out of every 5 nursing home residents in the country. The program pays a wide range of private health care and long-term care providers roughly \$360 billion a year (directly or through managed care organizations), which makes it one of the nation's largest purchasers of health care.

Medicaid is an "entitlement," meaning that anyone who meets eligibility requirements is entitled to enroll. On average, the federal government pays 57% of Medicaid costs, through what is known as the federal Medicaid "match." States and local governments pay the rest. As part of the American Recovery and Reinvestment Act (ARRA, the so-called stimulus bill) passed by Congress earlier this year, states will receive an extra \$87 billion in federal support, through an increase in the federal match, for 2009 and 2010.

Under Medicaid, there are specific groups of people whom states must cover in order to receive federal funding, as well as options available to states to add other groups. For example, states must provide Medicaid coverage to children ages 6–19 whose families have incomes that are equal to or below 100% of the federal poverty level, or FPL (see Exhibit 1 below for information on the federal poverty level in 2009). States must cover

infants and children under age 6 as well as pregnant women with incomes below 133% of the FPL. States also cover the elderly and people with disabilities who qualify for what is called "cash assistance" under programs like Supplemental Security Income, or SSI.

State options: At their option, states can and do raise the minimum eligibility requirements to allow more people into Medicaid. For example, in 20 states pregnant women with incomes up to 185% of the FPL can enroll. States cannot receive federal matching funds to cover adults who don't have dependent children, unless those adults are disabled; even so, 6 states do cover them through Medicaid, and 11 offer limited enrollment and benefits, under federal waivers they have received that exempt them from the rules. And under complicated rules, states can also extend Medicaid coverage to some recipients of Temporary Assistance to Needy Families, another form of cash assistance.

States can also add benefits under Medicaid. They're required to provide coverage for physician and hospital visits, lab tests, and nursing home and home health care, among other services. But they can also choose to add coverage for such items as prescription drugs and dental care.

The upshot is that Medicaid throughout the states is a patchwork. And although the program was designed to assist low-income people, it does not cover everyone with incomes below the federal poverty level. This is largely for three reasons: because eligibility requirements are set first by category, then by income; because eligibility requirements set by states vary widely for adults; and also because federal law limits coverage for single, childless adults. As a result of this patchwork, in fact, almost half of the nation's poor adults are uninsured.

CHIP basics: CHIP, the Children's Health Insurance Program, covers roughly 7 million children under age 19 whose family income exceeds the Medicaid limit but who are generally unable to afford private health coverage. Unlike Medicaid, CHIP is not an individual entitlement. The federal government pays a larger portion of the cost than it does Medicaid — on average, 70% — but the federal assistance to states comes in the form of a capped annual federal "allocation." The CHIP reauthorization enacted in February 2009 provided additional funds and incentives to states

EXHIBIT 1

2009 Federal Poverty Level and Proposed Changes in Federal Medicaid Income Eligibility

Family size	Federal poverty level (100%)	Current Medicaid eligibility for parents: up to 58% of FPL	133% of FPL (House bill)
1	\$10,830	\$ 7,364	\$14,404
2	14,570	9,908	19,378
3	18,310	12,451	24,352
4	22,050	14,994	29,327

Source: [U.S. Department of Health and Human Services](#).

to extend coverage to more children and to sign them up for the program.

The reauthorization law will enable CHIP to cover 4 million more uninsured children by 2013 — in other words, to reduce the number of uninsured children in the U.S. by about half. It will result in total federal spending on CHIP of roughly \$69 billion from fiscal years 2009 through 2013.

What's proposed?

The major health reform bills working their way through the House and under development in the Senate would expand Medicaid and create new options for families whose children are eligible for CHIP. But each sets or is expected to set different income eligibility limits, allows for different approaches for private insurance coverage, and specifies different arrangements for how states and the federal government will share the costs.

House bill: In the House of Representatives, the bill known as America's Affordable Health Choices Act of 2009 (HR 3200), unveiled by the Ways and Means, Energy and Commerce, and Education and Labor committees in mid-July 2009, includes these provisions:

- The bill would expand Medicaid to all individuals with incomes up to 133% of the federal poverty level. The cost of covering this new group would be fully paid for by the federal government.
- No state could reduce the eligibility levels or benefits in place for Medicaid beneficiaries as of June 30, 2009. In effect, this “maintenance of effort” provision means that new federal dollars to help expand Medicaid would go mainly to states that have had less generous eligibility levels and benefits in the past.
- Medicaid would cover all newborns for up to 60 days if they did not have coverage from other sources.
- Adults without dependent children who became newly eligible for Medicaid could instead sign up for private coverage through a Health Insurance Exchange, if they were enrolled in “qualified health coverage” during the 6 months before they became eligible for Medicaid.
- The bill would provide optional Medicaid coverage to low-income HIV-infected people, and the federal government would pay the same share of

these costs as it does for CHIP. States could also choose to provide Medicaid coverage for family planning services to certain low-income women; federal funds would cover 90% of the cost, as they do now.

- To expand the number of primary care providers willing to care for Medicaid populations, payment rates for primary care services would be increased with new federal funding.
- CHIP enrollees above 133% of the federal poverty level would be transitioned to obtain coverage through a new national Health Insurance Exchange in 2013, when the CHIP program is set to expire. Among the options they could choose from would be private coverage or a new public health insurance option. Families and children up to 400% of the FPL would be eligible for new federal subsidies to help them purchase coverage from the public plan or private plans.

The Congressional Budget Office (CBO) projects that 11 million more people would receive Medicaid coverage under the House bill. The CBO projects that the entire bill would cost \$1.042 trillion from FY 2010 through 2019. The estimated cost of the Medicaid and CHIP provisions is \$438 billion.

Senate discussions: In the Senate, the Finance Committee has jurisdiction over Medicaid and CHIP, and the panel has not yet finalized and “reported out” its health reform bill. The Senate Health, Education, Labor, and Pensions (HELP) Committee does not have jurisdiction over the two programs but has sketched a plan that it hopes the Finance Committee will follow. Here are some of the issues being debated among senators:

- If Medicaid eligibility is expanded on the basis of income, as the House bill proposes, should the House bill's threshold of 133% of the federal poverty level apply? HELP committee Democrats had suggested going up to 150% of the FPL, while a Senate Finance Committee discussion draft released in spring 2009 had suggested a lower threshold of 115% of the FPL.
- Should the federal government cover all of the costs of enrolling all of these people in Medicaid, as the House proposes?
- Should low- and moderate-income individuals and families with incomes too high for Medicaid, and up to 400% of the federal poverty level,

How Medicaid works

Federal law requires states to provide Medicaid coverage for these groups with these minimum annual income limits (as a percentage of the federal poverty level) in order to receive federal matching funds. States are free to set higher limits or request waivers to cover additional people.

- **Pregnant women and children** under age 6 in families with incomes below 133% of the FPL
- **Children** ages 6 to 18 whose families have incomes below 100% of the FPL
- **Parents** with incomes below states' July 1996 welfare eligibility levels, which range from 11% to 68% of the FPL
- **Elderly or disabled** low-income people who receive assistance from the Supplemental Security Income (SSI) program, which is about 74% of the FPL

How CHIP works

- **Federal dollars** match state spending (at an enhanced rate compared to Medicaid) for CHIP up to a capped amount specified by law, to provide health insurance to low-income, uninsured children under age 19.
- **States administer** their programs within broad federal rules, so eligibility and benefits can vary from state to state. As part of the CHIP reauthorization legislation, states have the option to cover legal immigrant children and pregnant women who have been in the country fewer than 5 years.
- **For families to qualify** for CHIP, family income levels must exceed the Medicaid limit.
- **States can cover** children in families above 300% of the federal poverty level, but the state will receive the lower Medicaid match rate (except in New York and New Jersey, which had raised eligibility levels before CHIP was reauthorized this year and get the higher CHIP match rate for covering children in families above 300% of the FPL).

be eligible for taxpayer-funded credits to help them purchase private health insurance coverage? Should such a proposal include families with children currently eligible for CHIP?

- Should these individuals and families described above also have the option of enrolling in some sort of newly created public health insurance plan, an as yet undefined “community health insurance option,” or new health insurance “cooperative”?
- Should states be able to use Medicaid dollars to help pay the costs of employer-sponsored health insurance for Medicaid-eligible individuals?
- Should CHIP eligibility be expanded, perhaps up to 275% of the federal poverty level?

What's the argument?

In favor of expanding government-sponsored health insurance for low-income people: Proponents of Medicaid expansion basically say there are few better alternatives. The insurance market does not offer affordable coverage for very-low-income people who do not currently qualify for Medicaid. Those who can't afford to buy private coverage, or who are excluded today from existing public health insurance programs, have very little likelihood of receiving private coverage unless it is very heavily subsidized.

Supporters also say that Medicaid and CHIP are more cost-effective than private insurance. They point to research that has found that private insurance is more expensive than Medicaid — as much as 26% more for a low-income adult and 37% more for a child, according to a study published last year in *Health Affairs*. (The difference is due to several factors, including lower payment rates to Medicaid providers.)

They also say it is more efficient to build upon an existing program structure that works, rather than to create something new that might not. Medicaid programs have put in place a range of delivery system reforms, including contracting with private managed care organizations to oversee the care for beneficiaries. Medicaid has long experience in providing and managing benefits for costly “high needs” populations, such as disabled children.

Supporters of Medicaid expansion say dollars spent on Medicaid can stretch further than dol-

lars spent on private coverage — for example, because Medicaid programs by law effectively get a discount on prescription drug costs, and because the programs have lower overhead costs than commercial insurers. To the degree that Medicaid spending has been rising, John Holahan and Alshadye Yemane describe in a forthcoming *Health Affairs* article, the cause has mainly been growing enrollment, not inefficiency of the programs.

Similar arguments apply to expanding CHIP coverage for children in families with low incomes. In addition, recent studies have shown that low-income children in CHIP or Medicaid are more likely than privately insured children to get preventive care. And although it has been challenging to enroll eligible children in the program, a study published in *Health Affairs* 2007 found that a streamlined application process would improve enrollment rates.

Supporters also say expanding Medicaid in the ways proposed will not destabilize private health coverage through a phenomenon known as “crowd-out.” When CHIP was first created in 1997, the CBO has concluded, for every 100 children who joined CHIP, 25–50 children disenrolled from a private plan. But this situation would not occur if Medicaid were expanded under current proposals, supporters say. Most of those who would become newly eligible for Medicaid don't have private coverage now, so they couldn't drop it. What's more, there are provisions in health reform legislation designed to maintain employer-sponsored private insurance and prevent workers from dropping that coverage to enroll in any public health plan. And requirements for employers to provide coverage — a so-called employer mandate — would further reduce the number of people able to switch from private to low-income government health coverage.

Against expansion: Objections to expanding Medicaid and CHIP come in several basic forms. Some critics aren't convinced of the urgency of moving toward “universal” coverage and broadening health insurance. They are concerned about adding to the burden that the federal and state governments already face from future liabilities for Medicare and Medicaid. Others simply don't think the federal government should spend any more dollars through public health insurance programs of any type. They would prefer that federal

dollars be used to subsidize the purchase of more private health coverage.

Notwithstanding the arguments of supporters, critics of expanding publicly funded health coverage still worry about “crowd-out.” They point to the House bill’s proposal to give families with children in CHIP the option of choosing not Medicaid, but rather a newly created public health insurance plan, through a Health Insurance Exchange. They continue to worry that a public plan would be at a steep competitive advantage to private insurers and could entice many with private insurance to drop those policies and switch into a cheaper, more generous public plan (see [Health Policy Brief, June 19, 2009](#)).

State concerns: Many governors, although in favor of expanding coverage, are also concerned about Medicaid and CHIP expansions and the effect on states. They acknowledge that the House bill would have the federal government cover the entire cost of the proposed Medicaid expansion. Yet governors are already worried about Medicaid shortfalls after 2010, when the extra federal support appropriated by Congress ends. And although they like the provision of the House bill that would allot more federal dollars to improve payments for primary care, they also think they will still have to come up with the money themselves to pay other providers more. Otherwise, Medicaid “expansion” would be in name only, since many health care providers would simply choose not to see Medicaid patients.

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What’s next?

As this brief is published, the outcome of health reform legislation remains uncertain. The House bill has been voted out of two of three committees — Ways and Means and Education and Labor — but not out of the third committee of jurisdiction, Energy and Commerce. Legislation has not yet emerged from the Senate Finance Committee, which has jurisdiction over Medicaid and CHIP. It appears increasingly unlikely that either the House or the Senate will vote on the legislation before the August recess.

In particular, the decision of how and whether to expand coverage for uninsured low-income people will depend in part on whatever Congress and the president decide is affordable. It will also depend on what can be paid for through additional revenues and any savings reaped through health care reforms. What’s more, those savings must be counted as “scorable” by the CBO. The less in revenue or savings that Congress is able to identify, the fewer people are likely to be covered through health reform legislation. If provisions of various bills are altered, there will be complex interactions between federal and state spending.

Regardless of what legislation eventually passes the House and Senate, the shape of any final health reform package will be ironed out in a congressional conference committee. The lawmakers who craft that package may agree on provisions that are different still from those discussed in this brief.

Resources

[“The America’s Affordable Health Choices Act of 2009”](#) (HR 3200, full text).

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Leighton Ku and Matthew Broaddus, [“Public and Private Health Insurance: Stacking Up the Costs.”](#) *Health Affairs* 27, no. 4 (2008): w318–w327 (published online 24 June 2008).

[Letter from Douglas Elmendorf, director, Congressional Budget Office, to Rep. Charles Rangel](#) (preliminary

cost estimates of HR 3200, “The America’s Affordable Health Choices Act of 2009,” as introduced on July 14, 2009), July 17, 2009.

Kaiser Commission on Medicaid and the Uninsured, [“Medicaid: A Primer.”](#) Kaiser Family Foundation, January 2009.

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U. S. Senate Finance Committee, [“Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans.”](#) May 14, 2009.